

Bilateral Cleft Lip Repair +/- Vomer Flap

Anaesthetist 1:

Anaesthetist 2:

Consultant:

Date of procedure: / /

1. Patient Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		2. Stage: First <input type="checkbox"/> Second <input type="checkbox"/> Single <input type="checkbox"/>	
3.a) Operation 1:	<input type="text"/>	4.a) OPCS4 Code 1:	<input type="text"/>
3.b) Operation 2:	<input type="text"/>	4.b) OPCS4 Code 2:	<input type="text"/>
3.c) Operation 3:	<input type="text"/>	4.c) OPCS4 Code 3:	<input type="text"/>
5. Cleft Classification: (LASHAL)	<input type="text"/>	6.a) Syndromic Cleft: Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>
7. Simmonarts Bands: Left <input type="checkbox"/> Right <input type="checkbox"/>	6.b) Type: <input type="text"/>		
9. PMH:	<input type="text"/>	8. PRS: Yes <input type="checkbox"/> No <input type="checkbox"/> NPA Used <input type="checkbox"/>	
11. Study Models: Yes <input type="checkbox"/> No <input type="checkbox"/>	10. Weight: Lbs <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> OZ OR Kg <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>		
13. Loupes: Yes <input type="checkbox"/> No <input type="checkbox"/>	12.a) Pre Op Photographs: Yes <input type="checkbox"/> No <input type="checkbox"/> b) Post Op Photographs: Yes <input type="checkbox"/> No <input type="checkbox"/>		
15. Operation Start time (24 hr clock - Knife to Skin): <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	14. Video: Yes <input type="checkbox"/> No <input type="checkbox"/>		
17. Local Anaesthetic: a) Type: <input type="checkbox"/> 0.25% bupivacaine with adrenaline <input type="checkbox"/> 0.5% bupivacaine with adrenaline <input type="checkbox"/> 2% lidocaine with adrenaline <input type="checkbox"/> other (Please specify) <input type="text"/>		b) Volume: <input type="text"/>	

18. DIAGRAM



* Complete if no study model

MEASUREMENTS (MM)		MEASUREMENTS (MM)	
19. Alveolar Cleft (Narrowest Distance)*	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>	30. Canthal Distance From	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>
20. Alveolar Cleft AP Distance*	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>	31. Columella Length - Start	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>
21. Premaxilla AP Displacement	<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Mild <input type="checkbox"/> Severe	32. Alar Base Width - Start	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>
22. Alveolar Cleft Transverse*	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>	33. Philtral Column Height	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>
23. Premaxilla Position	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Midline	34. Vermillion - Wet Dry junction Medial Element	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>
24. Alveolar Cleft Vertical*	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>	35. Vermillion Wet Dry (Lateral)	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>
25. Premaxilla vertical Displacement	<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Mild <input type="checkbox"/> Severe	36. Cupids Peak to Bow	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>
26. Mid Hard Palate*	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>	37. Position of ANS Deviation from Midline (mm)	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>
27. Hard Soft Palate Junction - Soft*	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>		
28. Intertuberosity Width*	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>	38. Columella Length	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>
29. Base of Uvula Width	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>	39. Alar Base Width - End	Right <input type="text"/> <input type="text"/> Left <input type="text"/> <input type="text"/>

a) RIGHT b) LEFT

40. VOMER FLAP (If no, go straight to question 49)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	LIP REPAIR	a) RIGHT	b) LEFT
41. Complete	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	49. Type of Repair	<input type="text"/>	<input type="text"/>
42. Distal Relieving Incision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	50. White Roll Triangle	<input type="text"/>	
43. Anterior Relieving Incision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	51. Vermillion Z or Triangle	<input type="text"/>	<input type="text"/>
44. Layers Closed	i. <input type="checkbox"/> Vomer & Palatine	i. <input type="checkbox"/> Vomer & Palatine	52. Prolabial Vermillion Retained	<input type="text"/>	<input type="text"/>
	ii. <input type="checkbox"/> Vomer & Nasal	ii. <input type="checkbox"/> Vomer & Nasal	53. Buccal Sulcas Release	<input type="checkbox"/> Medial <input type="checkbox"/> Lateral <input type="checkbox"/> None	<input type="checkbox"/> Medial <input type="checkbox"/> Lateral <input type="checkbox"/> None
45. Suture for Closure	<input type="text"/>	<input type="text"/>	54. Sub Periosteal Dissection	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
46. Tisseal	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	55. Alar Base Incision	<input type="text"/>	<input type="text"/>
47. Periosteoplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	56. Muscle Dissection	<input type="checkbox"/> Radical <input type="checkbox"/> Moderate <input type="checkbox"/> None	<input type="checkbox"/> Radical <input type="checkbox"/> Moderate <input type="checkbox"/> None
48. Turbinate Bone Graft	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	57. Muscle Score	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
			58. Muscle Tension	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3



NOSE		CLOSURE	
59. Septal mucosal dissection <input type="checkbox"/> Right <input type="checkbox"/> Left		65. Nasal Floor	<input type="text"/>
60. Septal Dissociation from ANS <input type="checkbox"/> Yes <input type="checkbox"/> No		66. Alar Base	<input type="text"/>
61. Nasal Dissection - Lateral Left <input type="text"/> Right <input type="text"/>		67. Mucosa / Vermillion	<input type="text"/>
62. Nasal Dissection - Medial Left <input type="text"/> Right <input type="text"/>		68. Muscle	<input type="text"/>
63. Score of Nasal Correction <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		69. Skin	<input type="text"/>
64. McCombs Dissection <input type="checkbox"/> Yes <input type="checkbox"/> No		70. McComb / Nasal	<input type="text"/>

71. Surgical Complications	a) <input type="checkbox"/> Yes <input type="checkbox"/> No b) If yes, please specify: <input type="text"/>
72. Transfusions	a) <input type="checkbox"/> Yes <input type="checkbox"/> No b) If yes, please specify volume in mls: <input type="text"/>
73. Anaesthesia	a) Type: <input type="text"/> b) Length: Hours <input type="text"/> Mins <input type="text"/> c) If yes, please specify: <input type="text"/> c) Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
74. Analgesia	a) Pre op: <input type="checkbox"/> Yes <input type="checkbox"/> No ai) If yes, please specify: <input type="checkbox"/> paracetamol <input type="checkbox"/> morphine iv <input type="checkbox"/> fentanyl <input type="checkbox"/> morphine NCA b) Intra op: <input type="checkbox"/> Yes <input type="checkbox"/> No bi) If yes, please specify: <input type="checkbox"/> paracetamol <input type="checkbox"/> morphine iv <input type="checkbox"/> fentanyl <input type="checkbox"/> morphine NCA c) Post op: <input type="checkbox"/> Yes <input type="checkbox"/> No ci) If yes, please specify: <input type="checkbox"/> paracetamol <input type="checkbox"/> morphine iv <input type="checkbox"/> fentanyl <input type="checkbox"/> morphine NCA
75. Tranexamic Acid	<input type="checkbox"/> Yes <input type="checkbox"/> No
76. Steroids	<input type="checkbox"/> Yes <input type="checkbox"/> No
77. Other	<input type="text"/>

POST OP INSTRUCTIONS	
78. Antibiotics Regimèn	<input type="checkbox"/> Nil <input type="checkbox"/> 24 hours post op <input type="checkbox"/> Other <input type="checkbox"/> On induction <input type="checkbox"/> 5-7 days post op
79. Antibiotic Drug	<input type="text"/>
80. Arms	<input type="checkbox"/> Splints <input type="checkbox"/> Mittens <input type="checkbox"/> Nil
81. Nasal Splints	a) <input type="checkbox"/> Yes <input type="checkbox"/> No b) Size: <input type="text"/> c) Brand: <input type="text"/>
82. Review Arrangements	<input type="text"/>

Signature: Date: / /

Name:

